



Clinical UM Guideline

Subject: Monitored Anesthesia Care and General Anesthesia for Cataract Surgery	Publish Date: 02/01/2018
Guideline #: CG-MED-60	Last Review Date: 01/25/2018
Status: Revised	

Description

This document addresses the medical necessity of monitored anesthesia care and general anesthesia services for cataract surgery. This document does not address topical, local, regional or moderate sedation ("conscious sedation") anesthesia. This document also does not address reimbursement for anesthesia services and is not intended to explain billing and reimbursement for anesthesia services.

Note: Please see the following related documents for additional information:

- [CG-MED-21 Anesthesia Services and Moderate \("Conscious"\) Sedation](#)
- [CG-MED-34 Monitored Anesthesia Care for Gastrointestinal Endoscopic Procedures](#)
- [CG-MED-41 Moderate to Deep Anesthesia Services for Dental Surgery in the Facility Setting](#)

Clinical Indications

Medically Necessary:

Administration of monitored anesthesia care (MAC) or general anesthesia for cataract surgery is considered **medically necessary** for any one of the following:

- Children less than 18 years of age; **or**
- Individuals who are unable to cooperate or communicate (for example, dementia, acute agitation, or movement disorder); **or**
- Individuals who are unable to lie flat (for example, severe back pain, congestive heart failure); **or**
- Individuals who have failed or have contraindications to topical, local, regional, or moderate sedation anesthesia; **or**
- Anticipation of prolonged or complex surgery.

Not Medically Necessary:

Administration of monitored anesthesia care (MAC) or general anesthesia for cataract surgery is considered **not medically necessary** for all other indications and when criteria above are not met.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CPT

00142 Anesthesia for procedures on eye; lens surgery [when specified as cataract surgery]

ICD-10 Diagnosis

E10.36 Type 1 diabetes mellitus with diabetic cataract

E11.36	Type 2 diabetes mellitus with diabetic cataract
H25.011-H25.9	Age-related cataract
H26.001-26.9	Other cataract
H28	Cataract in diseases classified elsewhere
Q12.0	Congenital cataract
Z98.41-Z98.49	Cataract extraction status

Discussion/General Information

Cataract is a clouding of the eye's lens. According to the Centers for Disease Control and Prevention (CDC), cataracts are the leading cause of vision loss in the United States affecting an estimated 20.5 million Americans over the age of 40 (CDC, 2015). Treatment of cataracts can include eyeglasses and brighter lighting. Definitive therapy includes surgery which removes and replaces the cloudy lens with an artificial lens.

Anesthesia during cataract surgery presents challenges as many of the participants are elderly and have comorbid conditions including cardiac or respiratory diseases. Anesthesia services are provided by or under the supervision of a physician. Services consist of the administration of an appropriate anesthetic agent and subsequent monitoring.

According to the American Academy[™] of Ophthalmology (AAO) Preferred Practice Pattern[®] for Cataract in the Adult Eye (2016), a variety of anesthesia techniques can be used during cataract surgery including local or regional anesthesia, and general anesthesia. While the preferred method of anesthesia is local or regional anesthesia, general anesthesia may be necessary depending on an individual's medical, psychosocial, or surgical condition.

In a 1999 prospective case series by Rosenfeld and colleagues, the authors sought to assess the need for MAC in those individuals who had cataract surgery. Participants were included from one facility and all received peribulbar anesthesia during their cataract surgery. A total of 1006 participants were included in the study. Some type of intervention by anesthesia personnel was required in 376 participants. Some participants required more than one type of intervention as evidenced by 548 total interventions. Interventions by anesthesia personnel included hand-holding, verbal reassurance, physical restraints, administration of supplemental regional blocks, intravenous sedation, treatment for hypertension, repositioning of jaw and neck, respiratory assistance, intravenous treatment for cardiac arrhythmias, and other miscellaneous types of intervention. An abnormal preoperative electrocardiogram (EKG) did not predict the need for intervention as 190/523 participants (36.3%) with abnormal EKGs and 165/437 participants (37.8%) with normal EKGs required assistance. For those with underlying medical conditions, there were no statistically significant correlations for the need for intervention. Out of 856 participants with known medical conditions intervention occurred in 328 (38.3%) and 48 (32%) of 150 healthy participants. The study results note that it is difficult to identify in advance of cataract surgery which participants would or would not benefit by the presence of anesthesia personnel. Underlying medical conditions and EKG results were not indicative of the need for anesthesia intervention.

Monitored Anesthesia Care (MAC) was developed in response to the shift to providing more surgical and diagnostic services in an ambulatory, outpatient or office setting without the use of the traditional general anesthetic. Accompanying this, there has been a change in the provision of anesthesia services from the traditional general anesthetic to a combination of local, regional and certain consciousness altering drugs. This type of anesthesia is referred to as MAC if directly provided by anesthesia personnel. Based on the American Society of Anesthesiologists (ASA) standards for monitoring, MAC should be provided by qualified anesthesia personnel (anesthesiologists or qualified anesthetists such as certified registered nurse anesthetists [CRNA]). These individuals must be continuously present to monitor and provide anesthesia care.

As described by the ASA's Position on MAC (2013):

Monitored anesthesia care is a specific anesthesia service for a diagnostic or therapeutic procedure. Indications for monitored anesthesia care include the nature of the procedure, the patient's clinical condition or the potential need to convert to a general or regional anesthetic.

Monitored anesthesia care includes all aspects of anesthesia care – a preprocedure visit, intraprocedure care and postprocedure anesthesia management. During monitored anesthesia care, the anesthesiologist provides or medically directs a number of specific services, including but not limited to:

- Diagnosis and treatment of clinical problems that occur during the procedure
- Support of vital functions
- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety
- Psychological support and physical comfort
- Provision of other medical services as needed to complete the procedure safely

As described by the ASA's Statement on Anesthetic Care During Interventional Pain Procedures for Adults (2016):

The use of moderate (conscious) sedation and/or anesthesia during the performance of pain procedures must be balanced with the potential risk of harm from doing pain procedures in sedated patients... Many patients can undergo interventional pain procedures without the need for supplemental sedation in addition to local anesthesia. For most patients who require supplemental sedation, the physician performing the interventional pain procedure(s) can provide moderate (conscious) sedation as part of the procedure. For a limited number of patients a second provider may be required to manage moderate or deep sedation or, in selected cases other anesthesia services. Examples of procedures that typically do not require sedation include but are not limited to epidural steroid injections, epidural blood patch, trigger point injections, injections into the shoulder, hip, knee, facet, and sacroiliac joints, and occipital nerve blocks.

Significant anxiety may be an indication for moderate (conscious) sedation or anesthesia services. In addition, procedures that require the patient to remain motionless for a prolonged period of time and/or remain in a painful position may require sedation or anesthesia services. Examples of such procedures include but are not limited to sympathetic blocks (celiac plexus, paravertebral and hypogastric), chemical or radiofrequency ablation, percutaneous discectomy, trial spinal cord stimulator lead placement, permanent spinal cord stimulator generator and lead implantation, and intrathecal pump implantation. Major nerve/plexus blocks are performed less often in the chronic pain clinic, but the Committee believes that these blocks may more commonly require moderate (conscious) sedation or anesthesia services (e.g., brachial plexus block, sciatic nerve block, and continuous catheter techniques). The Committee recognizes that pediatric patients may require sedation or anesthesia services for pain procedures because of age-related differences in the approach to this patient population.

The ASA (2014) defines general anesthesia as:

A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug induced depression of neuromuscular function. Cardiovascular function may be impaired.

In conclusion, there is no one definitive approach to anesthesia for cataract surgery. The use of anesthesia during procedures should be balanced with the potential risk of harm to those individuals who are sedated during pain procedures. This guideline does not address minimal or moderate (conscious) sedation, which is typically administered intravenously. It is a guideline for when MAC and general anesthesia, which require the service of an anesthesiologist, CRNA, or other certified personnel is appropriate and medically necessary as outlined in the clinical indications above.

References

Peer Reviewed Publications:

1. Rosenfeld SI, Litinsky SM, Snyder DA, et al. Effectiveness of monitored anesthesia care in cataract surgery. *Ophthalmology*. 1999; 106(7):1256-1260.

Government Agency, Medical Society, and Other Authoritative Publications:

1. American Academy™ of Ophthalmology. Preferred Practice Pattern®: Cataract in the adult eye. 2016. For additional information visit the AAO website: <https://www.aao.org/preferred-practice-pattern/cataract-in-adult-eye-ppp-2016>. Accessed on January 3, 2018.
2. American Society of Anesthesiologists. Continuum of depth of sedation definition of general anesthesia and levels of sedation/analgesia. (Approved by ASA House of Delegates on October 13, 1999, and amended on October 15, 2014). For additional information visit the ASA website: <http://www.asahq.org>. Accessed on January 3, 2018.
3. American Society of Anesthesiologists. ASA Physical Status Classification System. Approved by the ASA House of Delegates on October 15, 2014. For additional information visit the ASA website: <http://www.asahq.org>. Accessed on January 3, 2018.
4. American Society of Anesthesiologists. ASA Position on Monitored Anesthesia Care. (Approved by the House of

Delegates on October 21, 1986, and last updated on October 16, 2013). For additional information visit the ASA website: <http://www.asahq.org>. Accessed on January 3, 2018.

5. American Society of Anesthesiologists. Statement on anesthetic care during interventional pain procedures for adults. Approved by the ASA House of Delegates on October 22, 2005 and last amended on October 26, 2016. For additional information visit the ASA website: <http://www.asahq.org>. Accessed on January 28, 2018.
6. American Society of Anesthesiologists. Statement on Practice Recommendations for Pediatric Anesthesia. (Approved by the ASA House of Delegates on October 19, 2011 and reaffirmed on October 26, 2016). For additional information visit the ASA website: <http://www.asahq.org>. Accessed on January 3, 2018.
7. National Eye Institute. Facts about Cataract. Last Reviewed September 2015. Available at: https://nei.nih.gov/health/cataract/cataract_facts. Accessed on January 3, 2018.

Websites for Additional Information

1. Centers for Disease Control and Prevention. Common Eye Disorders. Last updated September 29, 2015. Available at: <https://www.cdc.gov/visionhealth/basics/ced/index.html>. Accessed on January 3, 2018.

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Anesthesia
Cataract

History

Status	Date	Action
Revised	01/25/2018	Medical Policy & Technology Assessment Committee (MPTAC) review. Re-scoped document to monitored anesthesia care and general anesthesia only. Title changed. Updated Description, Discussion/General Information, and References sections. Removed Definitions section. Coding section updated; removed CPT codes 99151, 99152, 99153, 99155, 99156, and 99157.
New	11/02/2017	MPTAC review. Initial document development.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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